General Assembly **Substitute Bill No. 457**

February Session, 2004 *____SB00457HS_APP031104___*

AN ACT CONCERNING RESTORATION OF SOCIAL SERVICES PROGRAMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 42 of public act 03-3 of the June 30 special session is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) **[**No earlier than September 1, 2003, but not later than October 1, 2003, the**]** The state-administered general assistance program **[**pursuant to this section and any general assistance program operated by a town**]** shall provide cash assistance of (1) **[**two hundred**]** three hundred fifty dollars per month to a single unemployable person upon determination of such person's unemployability; (2) two hundred dollars per month for a single transitional individual who is required to pay for shelter; and (3) one hundred fifty dollars per month for a single transitional individual who is not required to pay for shelter. **[**No earlier than September 1, 2003, but not later than October 1, 2003, eligible families shall receive cash assistance in an amount that is fifty dollars less than the standard of assistance such family would receive under the temporary family assistance program.**]** The standard of assistance paid for individuals residing in rated boarding facilities, shall remain at the level in effect on August 31, 2003. No individual shall be eligible for cash assistance under the program if eligible for

cash assistance under any other state or federal cash assistance program.

Sec. 2. Section 17b-257 of the general statutes, as amended by section 18 of public act 03-2 and section 43 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. **[**Not later than October 1, 2003, each**]** Each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance from a federally qualified health center. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. **[**Not later than October 1, 2003, each**]** Each person eligible for state-administered general assistance shall be entitled to receive hospital services. Medical services under the program shall be limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. In no event, shall ancillary or

specialty services provided under the program exceed such services provided under the state-administered general assistance program on July 1, 2003. Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person eligible for Medicaid shall be eligible to receive medical care through the state-administered general assistance program.

(b) Recipients covered by a general assistance program operated by a town shall be assigned and enrolled in federally qualified health centers and with any other providers in the same manner as recipients of medical assistance under the state-administered general assistance program pursuant to subsection (a) of this section.

(c) On and after October 1, 2003, pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Prior to said date, pharmacy services shall be provided as provided under the Medicaid program. Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services shall receive pharmacy services at pharmacies designated by the commissioner.

[(d) Recipients of state-administered general assistance shall contribute a copayment of one dollar and fifty cents for each prescription.**]**

[(e)**]** (d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The commissioner shall **[**, within available appropriations,**]** make payments

to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies.

[(f)**]** (e) Each federally qualified health center participating in the program shall, within thirty days of August 20, 2003, enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.

[(g)**]** (f) The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments to hospitals for inpatient services based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall **[**, within available appropriations,**]** make payments for any ancillary or specialty services provided to state-administered general assistance recipients under this section based on a methodology determined by the commissioner.

[(h)**]** (g) **[**On or before March 1, 2004, the**]** The Commissioner of Social Services shall seek a waiver of federal law under the Health Insurance Flexibility and Accountability demonstration initiative for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply

to this section.

Sec. 3. Subsection (b) of section 44 of public 03-3 of the June 30 special session is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) A recipient of state-administered general assistance cash assistance aggrieved by a decision of the Commissioner of Social Services under the program operated pursuant to section 42 of **[**this act**]** public act 03-3 of the June 30 special session may request a hearing pursuant to section 17b-60, **[**but shall not be**]** and shall remain eligible for the continuation of cash assistance pending a hearing decision.

Sec. 4. Section 17b-295 of the general statutes, as amended by section 55 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The commissioner **[**shall impose cost-sharing requirements including**]** may require the payment of a premium or copayment in connection with services provided under the HUSKY Plan, Part B **[**, to the extent permitted by federal law, and**]** in accordance with the following limitations:

[(1) On and after October 1, 2003, the commissioner may increase the maximum annual aggregate cost sharing requirements provided that such cost-sharing requirements shall not exceed five per cent of the family's gross annual income. The commissioner may impose a premium requirement on families, whose income exceeds one hundred eighty-five per cent of the federal poverty level as a component of the family's cost-sharing responsibility provided the family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement; and**]**

(1) On and after the effective date of this section, the commissioner shall submit a schedule for the maximum annual aggregate cost-sharing for families with an income: (A) Which exceeds one hundred eighty-five per cent of the federal poverty level but does not exceed

two hundred thirty-five per cent of the federal poverty level, and (B) which exceeds two hundred thirty-five per cent of the federal poverty level but does not exceed three hundred per cent of the federal poverty level to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, insurance and appropriations and the budgets of state agencies. Not later than fifteen days after the receipt of such schedule, said joint standing committees of the General Assembly shall advise the commissioner of their approval, denial or modifications, if any, of the schedule. If the joint standing committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be comprised of three members from each joint standing committee. At least one member appointed from each committee shall be a member of the minority party. The report of the committee of conference shall be made to each committee, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the schedule submitted by the commissioner shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval or modifications, if any, of the schedule, provided if the committees do not so advise the commissioner during the fifteen day period, the schedule submitted by the commissioner shall be deemed approved.

(2) The commissioner shall require each managed care plan to monitor copayments and premiums under the provisions of subdivision (1) of this subsection.

(b) (1) Except as provided in subdivision (2) of this subsection, the commissioner may impose limitations on the amount, duration and scope of benefits under the HUSKY Plan, Part B.

(2) The limitations adopted by the commissioner pursuant to subdivision (1) of this subsection shall not preclude coverage of any

item of durable medical equipment or service that is medically necessary.

Sec. 5. Section 17b-292 of the general statutes, as amended by section 7 of public act 03-2 and section 56 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed three hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B. **[**The services and cost-sharing requirements under the HUSKY Plan, Part B shall be substantially similar to the services and cost-sharing requirements of the largest commercially available health plan offered by a managed care organization, as defined in section 38a-478, offered to residents in this state as measured by the number of covered lives reported to the Department of Insurance in the most recent audited annual report.**]**

(b) A child who resides in a household with a family income over three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) A child who has been determined to be eligible for benefits under either the HUSKY Plan, Part A or Part B shall remain eligible for such plan for a period of twelve months from such child's determination of eligibility unless the child attains the age of nineteen or is no longer a resident of the state.

[(d)**]** (e) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for

the services or such equipment.

[(e)**]** (f) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his date of birth, provided an application is filed on behalf of the child within thirty days of such date.

(g) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. In establishing such regulations, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

[(f)**]** (h) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The servicer shall jointly market both Part A and Part B together as the HUSKY Plan. Such servicer shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part B to the commissioner who may transmit such data to the Children's Health Council.

(i) To the extent permitted by federal law, the single point of entry servicer may be one of the entities authorized to grant presumptive eligibility under the HUSKY Plan, Part A.

[(g)**]** (j) The single point of entry servicer shall send an application and supporting documents to the commissioner for determination of eligibility of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level. The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan.

[(h)**]** (k) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to make a determination on eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A and Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The determination of eligibility shall be coordinated with health plan open enrollment periods.

[(i)**]** (l) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(j)**]** (m) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 6. Subsection (c) of section 17b-297 of the general statutes, as amended by section 57 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner shall, within available appropriations, contract with qualified entities authorized to grant presumptive eligibility, severe need schools and community-based organizations for

purposes of public education, outreach and recruitment of eligible children, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of organizations. For the purposes of this subsection, (1) "community-based organizations" shall include, but not be limited to, day care centers, schools, school-based health clinics, community-based diagnostic and treatment centers and hospitals, and (2) "severe need school" means a school in which forty per cent or more of the lunches served are served to students who are eligible for free or reduced price lunches.

Sec. 7. Section 17b-290 of the general statutes, as amended by section 73 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in sections 17b-289 to 17b-303, inclusive, **[**section 72 of this act,**]** and section 16 of public act 97-1 of the October 29 special session*:

(1) "Applicant" means an individual over the age of eighteen years who is a natural or adoptive parent or a legal guardian; a caretaker relative, foster parent or stepparent with whom the child resides; or a noncustodial parent under order of a court or family support magistrate to provide health insurance, who applies for coverage under the HUSKY Plan, Part B on behalf of a child and shall include a child who is eighteen years of age or emancipated in accordance with the provisions of sections 46b-150 to 46b-150e, inclusive, and who is applying on his own behalf or on behalf of a minor dependent for coverage under such plan;

(2) "Child" means an individual under nineteen years of age;

(3) "Coinsurance" means the sharing of health care expenses by the insured and an insurer in a specified ratio;

(4) "Commissioner" means the Commissioner of Social Services;

(5) "Copayment" means a payment made on behalf of an enrollee for a specified service under the HUSKY Plan, Part B;

(6) "Cost sharing" means arrangements made on behalf of an enrollee whereby an applicant pays a portion of the cost of health services, sharing costs with the state and includes copayments, premiums, deductibles and coinsurance;

(7) "Deductible" means the amount of out-of-pocket expenses that would be paid for health services on behalf of an enrollee before becoming payable by the insurer;

(8) "Department" means the Department of Social Services;

(9) "Durable medical equipment" means durable medical equipment, as defined in Section 1395x(n) of the Social Security Act;

(10) "Eligible beneficiary" means a child who meets the requirements specified in section 17b-292, as amended by this act, except a child excluded under the provisions of Subtitle J of Public Law 105-33 or a child of any municipal employee eligible for employer-sponsored insurance on or after October 30, 1997, provided a child of such a municipal employee may be eligible for coverage under the HUSKY Plan, Part B if dependent coverage was terminated due to an extreme economic hardship on the part of the employee, as determined by the commissioner;

(11) "Enrollee" means an eligible beneficiary who receives services from a managed care plan under the HUSKY Plan, Part B;

(12) "Family" means any combination of the following: (A) An individual; (B) the individual's spouse; (C) any child of the individual or such spouse; or (D) the legal guardian of any such child if the guardian resides with the child;

(13) "HUSKY Plan, Part A" means assistance provided to children pursuant to section 17b-261, as amended by this act;

(14) "HUSKY Plan, Part B" means the health insurance plan for children established pursuant to the provisions of sections 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the October 29 special session*;

(15) "HUSKY Plus programs" means two supplemental health insurance programs established pursuant to section 17b-294 for medically eligible enrollees of the HUSKY Plan, Part B whose medical needs cannot be accommodated within the basic benefit package offered to enrollees. One program shall supplement coverage for those medically eligible enrollees with intensive physical health needs and the other program shall supplement coverage for those medically eligible enrollees with intensive behavioral health needs;

(16) "Income" means income as calculated in the same manner as under the Medicaid program pursuant to section 17b-261, as amended by this act;

(17) "Managed care plan" means a plan offered by an entity that contracts with the department to provide benefits to enrollees on a prepaid basis;

(18) "Parent" means a natural parent, stepparent, adoptive parent, guardian or custodian of a child;

(19) "Premium" means any required payment made by an individual to offset or pay in full the capitation rate under the HUSKY Plan, Part B;

(20) "Preventive care and services" means: (A) Child preventive care, including periodic and interperiodic well-child visits, routine immunizations, health screenings and routine laboratory tests; (B) prenatal care, including care of all complications of pregnancy; (C) care of newborn infants, including attendance at high-risk deliveries and normal newborn care; (D) WIC evaluations; (E) child abuse assessment required under sections 17a-106a and 46b-129a; (F) preventive dental care for children; and (G) periodicity schedules and reporting based on

the standards specified by the American Academy of Pediatrics;

(21) "Primary and preventive health care services" means the services of licensed physicians, optometrists, nurses, nurse practitioners, midwives and other related health care professionals which are provided on an outpatient basis, including routine well-child visits, diagnosis and treatment of illness and injury, laboratory tests, diagnostic x-rays, prescription drugs, radiation therapy, chemotherapy, hemodialysis, emergency room services, and outpatient alcohol and substance abuse services, as defined by the commissioner;

(22) "Qualified entity" means any entity: (A) Eligible for payments under a state plan approved under Medicaid and which provides medical services under the HUSKY Plan, Part A, or (B) that is a qualified entity, as defined in 42 USC 1396r-1a, as amended by Section 708 of Public Law 106-554 and that is determined by the commissioner to be capable of making the determination of eligibility. The commissioner shall provide qualified entities with such forms as are necessary for an application to be made on behalf of a child under the HUSKY Plan, Part A and information on how to assist parents, guardians and other persons in completing and filing such forms;

(23) "WIC" means the federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health pursuant to section 19a-59c.

Sec. 8. Section 17b-261 of the general statutes, as amended by section 10 public act 03-2, section 2 of public act 03-28, section 7 of public act 03-268 and section 63 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (d) of

this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence, pending federal approval, except that the medical assistance program shall provide coverage to persons under the age of nineteen up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Said medical assistance program shall also provide coverage to persons under the age of nineteen and their parents and needy caretaker relatives who qualify for coverage under Section 1931 of the Social Security Act with family income up to one hundred <u>fifty</u> per cent of the federal poverty level without an asset limit, upon the request of such a person or upon a redetermination of eligibility. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. All contracts entered into on

and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care organizations with the Healthy Families Connecticut Program established pursuant to section 17a-56. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance.

(b) For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

(c) For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to special needs trust, as defined in 42 USC 1396p(d)(4)(A).

(d) The transfer of an asset in exchange for other valuable consideration shall be allowable to the extent the value of the other valuable consideration is equal to or greater than the value of the asset transferred.

(e) The Commissioner of Social Services shall seek a waiver from federal law to permit federal financial participation for Medicaid

expenditures for families with incomes of one hundred forty-three per cent of the temporary family assistance program payment standard.

[(f) Notwithstanding the provisions of subsection (a) of this section, on or after April 1, 2003, all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level, who are receiving medical assistance pursuant to this section, shall be ineligible for such medical assistance. On and after February 28, 2003, the Department of Social Services shall not accept applications for medical assistance program coverage under Section 1931 of the Social Security Act from parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level until on or after July 1, 2005.**]**

[(g)**]** (f) To the extent permitted by federal law, Medicaid eligibility shall be extended for two years to a family who becomes ineligible for medical assistance under Section 1931 of the Social Security Act while employed or due to receipt of child support income or a family with an adult who, within six months of becoming ineligible under Section 1931 of the Social Security Act becomes employed.

[(h) An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse in order to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in Section 1924 of the Social Security Act. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in Section 1924 of the Social Security Act. The Commissioner of Social Services, pursuant to section 17b-10, may implement the provisions of this subsection while in the process of adopting regulations, provided the commissioner prints notice of intent to adopt the regulations in the Connecticut Law Journal within twenty days of adopting such policy. Such policy shall be valid until the time final regulations are effective.**]**

Sec. 9. (NEW) (*Effective from passage*) (a) The HUSKY Plan, Part B shall provide the following minimum benefit coverage:

(1) No copayments for preventive care and services;

(2) No copayments for the following medical services: Inpatient physician and hospital, outpatient surgical, ambulance for emergency medical conditions, skilled nursing, home health, hospice, short-term rehabilitation and physical therapy, occupational and speech therapies, lab and x-ray preadmission testing, prosthetics, durable medical equipment other than powered wheelchairs, dental exams every six months, x-rays, fillings, fluoride treatments and oral surgery. For the purposes of this subdivision, in accordance with the National Committee for Quality Assurance, an emergency medical condition is a condition such that a prudent layperson, acting reasonably, would believe that emergency medical treatment is needed;

(3) Outpatient physician visits, hearing examinations, nurse midwives, nurse practitioners, podiatrists, chiropractors and natureopaths;

(4) Prescription drugs;

(5) Eye care and optical hardware;

(6) Orthodontia;

(7) Mental health inpatient maximum of sixty days with allowable substitution of alternative levels of care and outpatient maximum of thirty visits with supplemental coverage available under a HUSKY Plus program for medically eligible enrollees, provided coverage under the HUSKY Plan, Part B and HUSKY Plus programs shall be consistent with the provisions of the Mental Health Parity Act, Public Law 104-204, and sections 38a-488a, 38a-514 and 38a-533 of the general statutes;

(8) Substance abuse treatment which shall include, detoxification and inpatient treatment for drug dependency for a period of time not

to exceed sixty days in a calendar year, detoxification and inpatient treatment for alcohol dependency for a period of time not to exceed forty-five days in a calendar year and outpatient visits for drug and alcohol dependency for a period of time not to exceed sixty days in a calendar year; and

(9) No deductibles shall be charged, no preexisting condition exclusion shall be applied, and there shall be no coinsurance or annual or lifetime benefit maximums.

(b) The Commissioner of Social Services may establish a schedule of reasonable copayments for coverage provided under subdivisions (3) to (8), inclusive, of subsection (a) of this section.

Sec. 10. (*Effective from passage*) Section 12 of public act 03-2, sections 69 and 72 of public act 03-3 of the June 30 special session and section 11 of public act 03-1 of the September 8 special session are repealed.

This act shall take effect as follows:	
Section 1	*from passage*
Sec. 2	*from passage*
Sec. 3	*from passage*
Sec. 4	*from passage*
Sec. 5	*from passage*
Sec. 6	*from passage*
Sec. 7	*from passage*
Sec. 8	*from passage*
Sec. 9	*from passage*
Sec. 10	*from passage*

HS *Joint Favorable Subst. C/R* APP